

MDR Tracking Number: M5-04-1522-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on January 28, 2004.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with § 133.308(r)(9), the Commission hereby Orders the respondent and non-prevailing party to **refund the requestor \$650.00** for the paid IRO fee. For the purposes of determining compliance with the Order, the Commission will add 20-days to the date the Order was deemed received as outlined on page one of this Order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. The unlisted modality, debridement and dressing changes, joint mobilization therapeutic exercises, ultrasound, hot/cold packs, office visits, myofascial release, manual therapy technique, physical therapy re-evaluation, electrical stimulation rendered on 4/11/03 through 10/6/03 were found to be medically necessary. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On April 7, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR	Rationale
10/2/03	97032 x 2	\$70.00	\$0.00	No EOB	$\$15.06 \times 125\% = \$18.83 \times 2 = \$37.66$	Review of the requestors and respondents documentation revealed that neither party submitted copies of EOBs, however, review of the recon HCFA reflected proof of submission. Therefore, the disputed services will be reviewed according to the Medicare Fee Schedule. The requestor submitted relevant information to support delivery of service. Reimbursement is recommended in the amount of \$198.92.
10/3/03	97140 x 2	\$90.00	\$0.00	No EOB	$\$24.72 \times 125\% = \$30.90 \times 2 = \$61.80$	
10/3/03	97032 x 2	\$70.00	\$0.00	No EOB	$\$15.06 \times 125\% = \$18.83 \times 2 = \$37.66$	
10/6/03	97140 x 2	\$90.00	\$0.00	No EOB	$\$24.72 \times 125\% = \$30.90 \times 2 = \$61.80$	
10/3/03 10/6/03	97110 x 2 97110 x 2	\$70.00 \$70.00	\$0.00 \$0.00	No EOB	$\$26.11 \times 125\% = \$32.64 \times 2 = \$65.28 \times 2 = \$130.56$	See rationale below.
TOTAL		\$460.00	\$0.00		\$329.48	

Rationale for CPT code 97110 rendered on 10/3/03 and 10/6/03: Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of the one-on-one therapy reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Additional reimbursement not recommended.

### ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this Order. This Order is applicable to dates of service 4/11/03 through 10/6/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 8<sup>th</sup> day of October 2004.

Margaret Q. Ojeda  
Medical Dispute Resolution Officer  
Medical Review Division  
MQO/mqo

April 5, 2004

Rosalinda Lopez  
Texas Workers' Compensation Commission  
Medical Dispute Resolution  
Fax: (512) 804-4868

Re: Medical Dispute Resolution  
MDR #: M5-04-1522-01  
IRO Certificate No.: IRO 5055

Dear Ms. Lopez:

\_\_\_ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, \_\_\_ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of \_\_\_ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine who is currently on the TWCC Approved Doctor List.

#### **REVIEWER'S REPORT**

##### **Information Provided for Review:**

Correspondence  
H&P and office notes  
Physical therapy notes  
Nerve Conduction Study  
Operative report

##### **Clinical History:**

This 36-year-old male claimant was involved in a work-related accident on \_\_\_, injuring his right wrist and low back. The claimant was immediately taken to the hospital emergency room where radiographic and CT imaging were taken. The claimant was

diagnosed with a burst fracture of L2, fracture of L1, right distal radius fracture, and right distal ulna fracture. At the hospital on 03/27/03, the claimant underwent surgery to reduce the comminuted fracture over the distal radius/ulna and the claimant was placed in an external fixator to stabilize the region. Physical therapy applications were initiated on 04/11/04. On 04/30/03, the claimant was advised that there may be a need to decompress the median nerve of the right distal upper quarter. On 05/01/03 the patient was advised to continue with physical therapy and antibiotics in the management of this claimant.

On 05/13/03 the external fixator was removed from the distal right upper quarter. A course of diagnostic/therapeutic steroidal injections were proposed on 05/16/03. No recommendations were made regarding physical therapy applications at this time. On 07/10/03, after a series of SI injections, the claimant was advised to continue with physical therapy applications. On 07/24/03, the claimant had neurodiagnostics performed over the upper quarter that revealed multiple traumatic neuropathies, including the median, ulna, and radial nerves. On 08/05/03 the claimant was advised that there is a degree of nerve root encroachment and continuing instability in the lumbar spine. Peer review on 02/17/04 revealed that passive modalities utilized beyond 05/11/03 were not necessary in the management of this claimant.

**Disputed Services:**

Unlisted modality, debridement & dressing changes, joint mobilization, therapeutic exercises, ultrasound therapy, hot/cold pack therapy, office visits, myofascial release, manual therapy technique, physical therapy re-evaluation, electrical stimulation, during the period of 04/11/03 through 10/06/03.

**Decision:**

The reviewer disagrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were medically necessary in this case.

**Rationale:**

The claimant did not suffer a strain/sprain injury. The reviewer's desire to classify this claimant in a strain/sprain therapeutic algorithm is not appropriate to the management of his claimant. This patient fell 25 feet from an oil derrick causing a burst fracture of L2, compression fracture of L1, comminuted distal radius fracture, and a comminuted distal ulna fracture. The right upper quarter had to be surgically reduced immediately, and an external fixator was provided for 6 weeks. The claimant did not sustain a simple strain/sprain injury.

This claimant's injuries are unique. The management of this claimant is not chiseled out in any standard guideline of clinical practice. Saying that this claimant should respond within 3-6 treatments of passive applications, just creates a ministry of delays with incorrect data. In this case, as in all physiotherapeutics, there must be a striving goal in the management of the claimant or the implementation of active, patient-driven therapeutics. It is not at all appropriate to believe that this claimant can be released to a home rehabilitation program to complete the same quality of activity that he would complete in a clinically supervised environment. Further, this claimant was being considered for surgical correction for right median nerve decompression and lumbar nerve root encroachment (instability). There is no data presented in these reviewed

medical records that does not warrant the therapeutic treatment by this provider from 04/11/03 through 10/06/03.

It is fundamental for the future management of this claimant that a psychosocial baseline of function along with a baseline of functional capacity be established so that the transition of this claimant to upper level therapeutics can be completed, if applicable.

The aforementioned information has been taken from the following guidelines of clinical practice and/or peer reviewed references.

- *Clinical Practice Guidelines for Chronic Non-Malignant Pain Syndrome Patients II: An Evan's Based Approach.* J Facts Musculoskeletal Rehabil 1999 Jan 1;13: 47-58.
- Frost H, et. al. *Randomized Controlled Trial For Evaluation of Fitness Program For Patients With Chronic Low Back Pain.* BMJ. 1995 Jan 21; 310 (69-73): 151-4.
- Roberts-Yates C. *The Concerns and Issues of Injured Workers in Relation to Claim/Injury Management and Rehabilitation: The Need for New Operational Frameworks.* Disabil Rehabil. 2003 Aug 19; 25 (16): 898-907.
- Hong H C, et. al. *Multidisciplinary Team Evaluation of Upper Extremity Injuries in a Single Visit: The Upper Program.* Occup Med (Lond). 2001 Jun; 51 (4): 278-86.

Sincerely,